NEBRASKA DEPARTMENT OF MOTOR VEHICLES

STATEMENT OF VISION

NOT VALID AFTER 90 DAYS FROM EXAMINATION DATE.

(Applicant completes before doctor's exam.)

By this form, or copy thereof, I hereby authorize and request the examining doctor to provide any information regarding my visual condition and history to the Department of Motor Vehicles, State of Nebraska.

Dated: _____ Signed: _____
(Applicant's Signature)

I hereby certify that I examined the eyes of _____
(Applicant's Name)

of _____
(Street Address) (City) (Zip Code)

Date of Birth License Number

(Required) To be completed by optometrist or ophthalmologist.

1. Unaided acuity: Both _____ Left Eye _____ Right Eye _____

2. a. Best correctable acuity: Both _____ Left Eye _____ Right Eye _____

   b. Visual acuity using telescopic lens: 20/_____ (Both) 20/_____ (Left) 20/_____ (Right)

   c. Visual acuity through carrier lens: 20/_____ (Both) 20/_____ (Left) 20/_____ (Right)

   d. Type of lenses used: Std. Spectacle _____ Aphakic _____

   Contact Lenses _____ Telescopic Lenses _____

3. Extent of entire horizontal form field, either binocular or monocular, as determined with a 330/5 mm Arc Perimeter or comparable instrument:

   Left Eye: _____ Degrees Temporal Right Eye: _____ Degrees Temporal

   _____ Degrees Nasal _____ Degrees Nasal

   Field of Vision looking through carrier lens: _____° Temp (Left) _____° Temp (Right)

   _____° Nasal (Left) _____° Nasal (Right)

4. Are <u>new</u> corrective lenses required? Yes _____ No _____

To be completed by optometrist or ophthalmologist. (Required)

5. Diplopia: (Check appropriate line)

_____ a. highly unlikely to occur

_____ b. intermittent* * Please Explain: _____

_____ c. constant* _____

6. If best visual acuity is less than 20/40 in either eye or both, or total horizontal form field is less than 140 degrees, give cause and probable prognosis under additional comments.

7. Based upon your examination has the vision condition of this patient, which was in existence prior to July 30, 1996, significantly worsened or another condition developed? ☐ No ☐ Yes

If yes, please explain _____

_____

8. In my opinion, this applicant should be retested in _____ years.

9. Color blindness (FOR COMMERCIAL DRIVERS ONLY): Able to recognize the colors of traffic signals and devices showing standard red, green and amber. ☐ No ☐ Yes

10. **Date of eye examination:** _____

(MUST BE COMPLETED - STATEMENT OF VISION NOT VALID AFTER 90 DAYS FROM EXAMINATION DATE)

Additional Comments: _____

_____

_____

_____

_____

_____

_____ _____

Name of Optometrist or Ophthalmologist (Please Print)

Signature of Optometrist or Ophthalmologist*

_____

Address of Optometrist or Ophthalmologist (Please Print)

Telephone Number of Optometrist or Ophthalmologist: (____) _____

Fax Number of Optometrist or Ophthalmologist: (____) _____

***If the applicant needs new corrective lenses to get the best correctable acuities listed on page 1, please delay signing this statement until the new lenses are in use by the applicant.**